Small Steps/Big Differences

The Medical Home Partnership

Practical Tips for Physicians Caring for Children with Special Health Care Needs
Developed for use for the ND Catch Grant by Family Voices of ND

The American Academy of Pediatrics, The American Academy of Family Physicians and the Maternal and Child Health Bureau are promoting Medical Home partnerships between families caring for children with special health care needs and the physicians they trust. In a Medical Home, families and physicians work together to identify and access all the medical and non-medical services needed to help children with special health care needs and their families reach their maximum potential.

A Medical Home partnership enhances the effectiveness of the patient-family-doctor relationship, not by working harder and faster but by doing things differently.

Medical Home is not a building, house or hospital. It is an approach to providing health care services in a high-quality and cost-effective manner.

Medical Home is as much an attitude as it is a way of delivering care; families are recognized as the principle caregivers and the center of strength and support for children.

Medical Home is another way of describing a physician's office when it helps families access the full range of services and supports needed to care for a child with special needs.

WHY invest in Building a Medical Home Partnership?

The number of children and youth with chronic or disabling conditions is rising. Advances make it possible for persons of all ages to be cared for in the home and community, but this requires new approaches to care and new systems of supports.

All primary care physicians who care for children have some children with special health care needs in their practice.

Purchasers are increasingly using patient satisfaction measures as an indicator of quality care.

Breakdown in communication and connections between patients and their physicians are among the primary reason why consumers change providers and, in severe cases, take legal action.

WHO ARE CHILDREN WITH SPECIAL HEALTH CARE NEEDS?

Recent data for the National Center for Health Statistics estimate 13% of children nationwide have a special health care needs that fits this definition.

All physicians who care for children will have patients and families with special health care needs in their practice. Children and youth with special health care needs are recognized to be those from birth to 21 years old who:

Have a chronic physical, developmental, behavioral, or emotional condition expected to last 12 months or more, and need health and related services more than most children. Children may receive these services from various public and private agencies in the areas of health, education and social services. As a result of complex conditions and many different providers, families and providers may need help in coordinating this care.

This list is not inclusive but may include children with conditions such as diabetes, sickle cell anemia, cystic fibrosis, heart disease, developmental

Making it Happen, ONE STEP at a TIME…

Practical tips for physicians, nurses and office staff

Step 1: BEFORE THE VISIT—Anticipate Special Needs

Appointment Scheduling & Medical Record- Identify patients with special health care needs in the scheduling system. Use a special sticker or different colored chart. Include critical needs at front of medical record such as: allergies, larger exam room, best way to take height and weight, scheduling when extended visits are possible.

Reception and Waiting Area-Greet by name families and patient who call or come to office. Ask the family to fill out a brief "Concern of the Day" form to identify new issues or pressing needs. Use the waiting room to share information about programs and resources useful to families. Be mindful of challenges faced in the waiting room due to

Step 2: IN THE EXAM ROOM/Use Family as Experts

Adjust Routine Procedures: Ask for advice before starting any procedures. "Is there anything I should know about your child?" Delay most routine aspects of the exam when there is an urgent need until after the physician has attended to the immediate concern. In cases where a child is examined frequently, the physician may decide it is not necessary to weigh or undress the child at each visit, sparing the parent and child difficulty or discomfort.

Assess Unmet Needs: Review the "Concern of the Day" form to facilitate conversation. Ask questions about the impact of the child's condition on the family—on siblings, work, finances, fatigue and assess the support systems in place. Encourage family to discuss other facets of their child's life including in-home care, education, recreation and socialization. Offer to help explain the child's medical needs to other health, education or community professionals.

Use written Plans for Care: Acknowledge the family's need to communicate medical

Step 3: AFTER THE VISIT-Help Coordinate Care

Help find resources: Identify a staff member or community-based care coordinator to help families find needed services and implement care plans. Connect families to community resources, such as specialized transportation, durable medical equipment or home care. Maintain telephone numbers of public agencies, including Family Voices of North Dakota, ND Family to Family, Children's Special Health Services, etc.

Maintain Linkages with Specialists: Ensure continuity of care and updated information by working to improve timely communication with medical specialists. Help families make sense of clinical recommendations they may receive from different providers. Organize or participate in team meetings with multiple providers to achieve agreement on plans for care.

Paying the Bills: Assign a staff member to help with referrals, payment issues and follow-up activities to assist family to coordinate financial benefits and reimbursement. Keep a resource list so you can to reach the special case management programs within

Step 4: IN THE COMMUNITY-Work Collaboratively with Families

Family & Staff Participation: Seek the input of families in your practice to find ways to make the office more user-friendly and family centered. Identify potential parent leaders who may be interested in supporting other families. Invite staff with interest and skills in working with families to build the Medical Home partnership in your practice.

Parent to Parent Support-Learn about parent support groups in your community and encourage families to connect. Post notices about meetings and events in the waiting room. Offer your office facility for evening meetings.

Families as Advisors: Include parents on existing practice-based committees that